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Kentucky Employees' Health Plan
Department of Employee Insurance
www.KEHP.KY.GOV ● 1-888-581-8834

2011 KEHP ACTIVE EMPLOYEE ENROLLMENT/CHANGE APPLICATION

Insurance Coordinator/HR Generalist Section

Date of Hire ____/____/_____ Coverage Effective Date ____/____/_____ Company Name _____

Company Number _____ Organizational Unit Number _____

Employee's Personnel Number _____ Employee's SSN _____

Reason for Application

	New Hire
	Open Enrollment
	New Group
	QE
	Other/ Reason:

If QE – Select Reason **Date of Event: ____ /____ /____**

Deletion of Dependent

	Divorce
	Death
	Loss of Eligibility
	Gaining Other Coverage
	Gaining Medicare/Medicaid
	Other/Reason:

Addition of Dependent

	Marriage
	Birth/Adoption of Child
	Guardianship/Court Order
	Loss of Other Coverage
	Loss of KCHIP/Medicaid
	Re-establishing Eligibility
	Special Enrollment

Demographic Information

I am covered under: ❑ A KY retirement plan ❑ My Hazardous Duty Plan ❑ My Spouse's Hazardous Duty Plan ❑ Medicare Supplement ❑ I am a Dual Employee

Name (Last, First, Middle Initial) _____ **Date of Birth** (Month/Day/Year) _____

Home Address _____ **City, State, Zip** _____ **Home County** (Code/Name) _____

Home Phone Number _____ **Cell Phone Number** _____ **E-mail Address** _____

Gender ❑ **Male** ❑ **Female** | **Marital Status** ❑ **Married** ❑ **Single** | **Have you smoked in the last 2 months?** ❑ **Yes** ❑ **No**

Dependent Information

SOCIAL SECURITY NUMBER	NAME (Last, First, Middle Initial)	BIRTH DATE MONTH/ DAY/ YEAR	GENDER	Cross Reference Payment Option (LRC, JRC not eligible) ❑ Yes (Employee, Employee & child(ren))
Spouse		___/___/___	❑ Male ❑ Female	

Spouse's Company Number: ❑ Dual Employee ❑ Hazardous Duty Date of hire/retirement ___/___/___ **Has Spouse smoked in the last 2 months?** ❑ Yes ❑ No

Spouse's Organizational Unit Number:

Child 1		___/___/___	❑ Male ❑ Female	❑ Natural ❑ Adopted ❑ Court Ordered ❑ Foster ❑ Step ❑ Disabled
Child 2		___/___/___	❑ Male ❑ Female	❑ Natural ❑ Adopted ❑ Court Ordered ❑ Foster ❑ Step ❑ Disabled
Child 3		___/___/___	❑ Male ❑ Female	❑ Natural ❑ Adopted ❑ Court Ordered ❑ Foster ❑ Step ❑ Disabled

Plan Election

Benefit Options

- ❑ **Commonwealth Standard PPO**
- ❑ **Commonwealth Maximum Choice**
- ❑ **Commonwealth Capitol Choice**
- ❑ **Commonwealth Optimum PPO**

Coverage Level

- ❑ **Single (self only)**
- ❑ **Parent Plus (self and child(ren))**
- ❑ **Couple (self and spouse)**
- ❑ **Family (self, spouse and child(ren))**

❑ **Waiver (No Health Insurance)** ⇨ ❑ **$175/month HRA** ❑ **No HRA (not eligible)**

Plan Year 2011

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Employee's SSN

Authorization and Certification

I understand and agree that:

- I have made the above plan selection for plan year 2011.
- My signature on this application creates a legal and binding contract between myself, the Department of Employee Insurance (DEI), Kentucky Employees' Health Plan (KEHP) and any TPAs.
- If my spouse and I elect the cross-reference payment option, we are dual plan holders with Family coverage and that upon a loss of eligibility by either spouse, the remaining plan holder will default to Parent Plus coverage. The cross-reference payment option ceases upon loss of eligibility or employment by either spouse/plan holder.
- I certify that each dependent I am enrolling meets the eligibility requirements of a dependent as set forth in the Summary Plan Description(s) and in the KEHP Benefits Selection Guide. I understand that DEI requires supporting documentation to verify the eligibility of any dependent enrolled or requesting to be enrolled in the Plan. And, in addition, an affidavit **2011 Certification of Dependent Eligibility** must be submitted for dependent children between the ages of 19-25.
- All benefits for myself and eligible dependents be provided in accordance with the Summary Plan Description(s).
- I will abide by the terms and conditions governing membership and receipt of services from the plan in which I have enrolled.
- The elections indicated on this application may not be changed or cancelled during the Plan Year, with the exception of certain Qualifying Events.
- I authorize my employer to deduct from my earnings the amount required to cover my share of the coverage I have selected, including any arrears I may owe. I authorize payment of my employee contributions to be made on a pre-tax basis unless I sign a Post-Tax Form.
- If I elect to waive KEHP medical coverage, with or without a stand-alone Health Reimbursement Account (HRA), I am doing so voluntarily and intentionally.
- Regarding my HRA, any dependents for which I claim reimbursement are eligible to seek such reimbursement.
- I have a 90-day run-out period (until March 31) for reimbursement of eligible HRA expenses incurred during my period of coverage.
- My Humana*Access*SM Visa®Card will be suspended if the required HRA claim verification is not sent in within sixty (60) days after the card swipe. I agree to follow all rules and guidelines established by the plan concerning the Humana*Access*SM Visa®Card.
- This Plan reserves the right to deny access to the card, require repayment, deduct/withhold from your paycheck and offset your HRA if you fail to properly substantiate your HRA claims.
- This plan has a tobacco incentive for members who do not use tobacco and that this plan offers tobacco cessation programs.
- Plan terms permit rescission of coverage with respect to an individual if the individual engages in an act, practice, or omission that constitutes fraud or makes an intentional misrepresentation of a material fact.
- I have rights under HIPAA and that DEI will comply with the HIPAA rules and that disclosure of protected information will be done under the rules of such Federal Law. I further authorize DEI to use such information and to disclose such information to business associates, third party administrators, vendors, consultants, governmental agencies with jurisdiction and other necessary parties when necessary for my care or treatment, payment for services, the operation of my health plan or to conduct related activities.
- Any person who knowingly, and with the intent to defraud any insurance company or other person, files an application for insurance containing any forged signature or incorrect signature date thereto commits a fraudulent insurance act, which is a crime. I understand that I can be held responsible for any fraudulent act that is the result of a forged signature or incorrect signature date that I could have prevented while acting within my duties related to the KEHP and it may be used to reduce or deny a claim or to terminate my coverage.
- I have fully read the materials provided to me. My signature below certifies that all information, signatures and signature dates affixed to this contract are correct to the best of my knowledge.

PLEASE SUBMIT THIS APPLICATION TO YOUR COMPANY INSURANCE COORDINATOR OR HRG

Employee Signature _____ Date _____

Spouse Signature – *REQUIRED* if electing the cross-reference payment option _____ Date _____

Insurance Coordinator/HRG Signature _____ Date _____

Spouse's Insurance Coordinator/HRG Signature – *REQUIRED* if electing the cross-reference payment option _____ Date _____